MELANCHOLIA, PERIODICAL DEPRESSION, AND OTHER DEPRESSIONS, WITH DIFFERENTIAL DIAGNOSIS.

J. M. KENISTON, M.D.,

MIDDLETOWN.

Depression is defined by Webster as follows:

The state of being depressed or cast down; a sinking.

Humiliation or abasement.

Dejection or despondency.

Synonym: melancholy.

Melancholy is defined thus:—A gloomy state of mind, often of some continuance, or habitual; depression of spirits induced by grief; dejection of spirits. Hence gloom of mind; great and continued dejection of spirits; dejection.

Depression is defined by the Century Dictionary as follows:—A sinking of the spirits; a state of being pressed down; dejection; a state of sadness; want of courage or animation.

Depression is such a prominent feature in some forms of insanity that the term melancholia has been applied to a large group of psychoses which on recent analysis are found clinically to present different pictures, which justify their classification in a more scientific way. The trouble, heretofore, has been in giving too much prominence to an emotional attitude, without regard to concomitant symptoms, the onset, course, and termination of the psychoses. The same error has occurred in regard to exaltation, or "mania."

Depression is a prominent element in the following psychoses, viz: Manic-depressive (periodical) Insanity, Melancholia, Dementia Paralytica, (General Paresis),

Dementia Precox, Dementia Senilis, Neurasthenia, and Hysteria.

In each it is colored or modified by other fundamental symptoms, and as the outcome of each is different it is of interest and importance to ascertain as early as possible in the course just what form the depression will assume, and its bearing upon the further development and outcome of the disease. In the limited space at the writer's disposal, an attempt will be made to briefly describe the symptoms of some of the above mentioned psychoses, and to present material for their differentiation. The task is difficult, and if clearness has been sacrificed to condensation, it is hoped that none of the important features have been omitted.

MANIC-DEPRESSIVE (PERIODICAL) INSANITY.

This name is applied to that mental disorder which recurs in definite forms at intervals throughout the life of the individual.

The greater number of cases usually called recoverable mania, simple mania, simple melancholia, periodical mania or melancholia, and circular insanity, belong to this group. According to the old conception, these diseases presented difficulties because of the frequent occurrence of conflicting symptoms. In periodical melancholia, there appeared evident maniacal symptoms, and conversely. "Any series of ten cases of 'periodical mania or melancholia,' in each of which there have been at least three attacks closely observed, discloses such varying features that one is forced to conclude that these manifestations, inharmonious with the old conceptions, are not accidental, but phases of one disease process. The constant recurrence of certain fundamental symptoms in all the attacks, the uniformity of their course and outcome, and the occasional intimate relation of different forms of the disease, where one form passes over either gradually or rapidly into another, has led to the

conclusion that the individual attacks appear in one of three forms, viz.: the maniacal, the depressive, or the mixed." —A. R. Defendorf.

The depressive forms are characterized by psychomotor retardation, absence of spontaneous activity, dearth of ideas, dejected emotional attitude, prominent delusions and hallucinations and considerable clouding of consciousness.

Depressive States. These are divided into three groups,—simple retardation, retardation with hallucinations and delusions, and the stuporous condition.

1. Simple retardation, in which there are neither hallucinations nor delusions. The onset is generally gradual. Mental processes are retarded; a mental sluggishness gradually appears; thought becomes difficult; the power of decision and verbal expression is impaired. Attention is difficult, and there is a lack of usual interest in surroundings. There is poverty of thought and the association of ideas is delayed. It is hard to remember or think. There is great constraint in speech and in all movements. Emotionally there is a uniform depression. Life has lost its charms; everything is a failure; religious faith is lost; death is desired, although suicidal attempts are infrequent. The course is rather uniform, improvement is gradual, and the duration varies from a few months to over a year.

2. Retardation with delusions and hallucinations. Here we have delusions of persecution and self-accusations in addition to retardation and difficulty of thought. Hypochondriacal delusions are prominent; patients are self-centered and think only of their own misfortunes. They are dejected, gloomy, and perplexed, and sometimes lament for hours in low and monotonous tones.

Psychomotor retardation is evident in the slow and hesitating replies, and in slow and languid movements. There is seldom any independent action. At times

there may be considerable anxious restlessness, when patients pace to and fro, sway the body, pick at the clothing, rub the head, etc. Physically, there is numbness in the head, oppression of the chest, palpitation, anorexia, constipation, impaired and dreamy sleep, lusterless eyes, and sallow skin.

As the depression and retardation are fully described in the differentiation of the disease, no delineation is needed here.

The term melancholia is restricted to certain conditions of mental depression occurring during the period of involution, and must be distinguished from the melancholia of many writers who apply the term to any condition of depression, whether it enters into the picture of paresis, dementia precox, manic-depressive insanity, etc. The psychosis is an evidence of beginning senility, the majority of cases occurring between the ages of forty and sixty. Sixty per cent. are women, in whom there is a relation to the climacteric, while in men the onset is later.

The symptoms are:—

A. Prodromal, often lasting for months; most prominent are persistent headache, vertigo, insomnia, indefinite pains, general debility, anorexia, constipation, palpitation, and increasing incapacity for work.

B. Typical. Sadness, dejection, apprehension, doubts, fears, self-accusations, are very characteristic, and patients not only accuse themselves of present sins but review and condemn many trivial errors in their past life, even as far back as childhood. "I asked a sick sister to keep out of the kitchen;" "at my mother's death I thought about the division of property," etc.

Religious elements are often prominent. Many have not been fervent in prayer, possess no true religious feelings, have "committed the unpardonable sin," "are eternally lost," etc.

Delusions of fear are common. Patients will be evicted from home, cast into prison, be tortured, must starve, etc. Fear is a very prominent and characteristic symptom of melancholia.

Hypochondriacal delusions are frequent. The stomach is gone, the brain rotten, etc.

Delusions often cause seclusiveness and refusal of food.

Hallucinations of hearing and sight may be present at some time during the course, but are not essential to the picture.

Thought centers on depressive ideas, which constantly recur, but there is no characteristic retardation.

On the whole, the conduct is in complete accord with the depression and delusions. Hence while we see some patients indolent, inert, motionless for hours, etc.; others are very restless, sigh, groan, weep, wring their hands, ejaculate "oh, God," etc. Suicidal attempts are frequent, and are often due to sudden impulses or to fear.

The facies in melancholia is very characteristic. The jaws are not firmly closed, giving the face an elongated appearance; the forehead is puckered by several parallel transverse wrinkles, with several vertical wrinkles in the middle; the corners of the mouth are drawn downwards; and the whole expression indicates fear, dejection, or even despair.

Dementia Paralytica (general paresis) is a chronic psychosis of middle life, characterized clinically by progressive mental deterioration with ultimately absolute dementia, and paralysis. It affects more men than women, in the proportion of four or five to one.

We now recognize four forms of paresis, viz.: demented, expansive, agitated, and depressive. The disease rarely appears before the age of twenty-five or after fifty-five, and is most frequent between the ages of thirty-five and forty. The onset is later in women than in

men; women suffer more often from the depressive form; and hence in them we must differentiate especially between paresis and melancholia.

At present we are concerned only with the depressive form, whose onset is insidious, and which is characterized through the entire course by the depressive tone of the emotions and delusions.

Prominent symptoms are failing memory, decreasing power of application, greater fatigue upon exertion, and despondency over the physical condition. Soon hypochondriacal delusions appear, and at this time many patients are regarded as neurastheniacs.

The delusions soon become senseless and may be associated with self-accusations. Delusions of persecution may appear. The depression is not always uniform, and brief periods of a feeling of well-being may intervene. At times there is stupor, and again active manifestations of grief, sadness and anxiety. In a word the depression is colored by the blunting of emotions due to progressive deterioration, and the effect is much less than in melancholia or manic-depressive insanity. Hence neither expression nor conduct show decided signs of depression.

The course of the depressed form of paresis is rather short, the greater number dying within two years.

Dementia Precox includes the Hebephrenia of Hecker and Kahlbaum, (1891); the Catatonia of Kahlbaum, (1874); and the Paranoid Dementias, including the form formerly described by Kraepelin as Fantastic Paranoia. The disease comprises 14 to 20% of all admissions to hospitals; and in more than 60% of cases the onset occurs before the twenty-fifth year. Defective heredity appears in about 70% of cases.

Many cases present mental and moral peculiarities from youth up, as seclusiveness, precocious piety, impulsiveness, and susceptibility to alcohol, while at least 7% have always been weak-minded. Various stigmata are

occasionally observed, as asymmetries, malformations of palate and ears, etc.

While the disease picture appears varied, yet certain fundamental symptoms usually permit early recognition of the psychosis. Patients are usually well oriented for time, place, and person, except in transitory excitement, in catatonic stupor, or during presence of hallucinations, but even then many events in the environment are appreciated. Hallucinations of hearing are most prominent, next those of sight, and rarely of touch.

Voluntary attention is decidedly impaired.

Memory begins to deteriorate from the onset. School knowledge may be retained to some extent, but new ideas are not readily, if at all, apperceived and assimilated. Even in the early stages there is a characteristic looseness of thought with some distractibility and flightiness.

Judgment is impaired very early, and numerous silly or fantastic delusions appear, which later become unstable and changing, or subject to additions.

In addition to mental deterioration we always find emotional deterioration. Lack of interest in, or indifference to surroundings, home, family relations, personal affairs, etc., may be the first symptom noted.

Depression and anxiety may appear early, or at various periods during the course, but is rarely profound, except in catatonia, and does not profoundly influence the conduct or produce marked affect, as in melancholia

There is rather indifference or even apathy. Even in depression patients may laugh or smile in the silly manner so characteristic of hebephrenia.

In catatonia we often have a preliminary period of depression, followed by one of excitement, and later development of stupor, negativism (mutism, refusal of food, passive resistance) automatism, muscular tension (flexibilitas cerea) stereotypy, verbigeration, and echolalia. Depression in catatonia is more marked than in the other forms of dementia precox, and will be considered in the differentiation.

The differentiation of the depressive forms of manic-depressive insanity from the depressed form of paresis is easy when there is a history of previous depressive or maniacal attacks. But in first attacks of periodical insanity in middle life or later, the diagnosis cannot be established from the condition picture alone. When patients are conscious and ordered, the presence or absence of disturbances of memory, weakness of judgment, and pliancy, have special significance. A simple alteration of disposition and the occasional appearance of pressure of activity and light expansive ideas, are to be utilized only with the greatest caution for the assumption of dementia paralytica, on account of the possibility of a change to a maniacal condition. The absence of any signs of mental or moral deterioration, and the presence of retardation makes for manic-depressive insanity.

In stuporous states the manic-depressive patients apprehend their surroundings much better than paretics, but show more motor restraint; hence they pay greater attention to events in their neighborhood, are more easily depressed, move seldom and slowly, show discomfort at interference, and sometimes give vent to their internal excitement in whispered soliloquies. In contrast to this paretics manifest no concern about the external world, hardly notice threatened dangers, are more free in their movements, and either restless, or dull and inaccessible. In single cases it is naturally not always possible to obtain clear views of the inner mental processes of the patients, and differentiation would be slow, unreliable, and often impracticable without consideration of the physical symptoms, which, though sometimes uncertain, are usually more decided and prominent in paresis.

Melancholia is differentiated first by the onset at the period of involution, although a few cases of manic-depressive arise at this time. In the latter the rapid and favorable course with single maniacal symptoms, as

pressure of activity, flight of ideas, exaltation, without any evidence of deterioration make the differentiation possible. The psychomotor attitude furnishes the best guide. While the entire behavior of the melancholiac pictures the natural expression of his depressed or fearful mood, in manic-depressive insanity the volitional incapacity, retardation, etc., are very prominent.

The depressive states must above all be differentiated from the initial depression of dementia precox. It lies in the discrimination of negativism from psychomotor retardation. The clear consciousness, absence of disturbance of thought, and especially the social obtuseness seen in the latter are in marked contrast to the stupefaction, insensibility, and sorrowful or uneasy disposition of periodical (manic-depressive) insanity.

The early appearance of numerous hallucinations and senseless delusions must always awaken the suspicion of catatonia. Here the disposition is strikingly indifferent; patients take no part in their environment, do not greet their relatives, are often mute, but devour greedily all food given them. In depressive states we never miss an inward anguish or deep sadness. Here visits of friends can lead to sudden and extremely severe outbursts of grief.

It is very important not to confuse the negativism of the catatonic with the anxious resistance and retardation of the depressed periodic. In the former we see rigid and stubborn resistance to every attempt at change of position, especially on actual interference, while simple and even dangerous threats (needles in the eyes) are usually endured without earnest defence, and finally the resistance passes over into automatism, either spontaneously or under the influence of cautious compulsion.

In manic-depressive on the other hand, the resistance begins with the threatened danger, just the same, whether a change of position does or does not take place; also when their limbs are placed in different positions pa-

tients do not often assume the earlier attitude with invincible tenacity, like the catatonics. The stuporous catatonic moves about very little or not at all, especially on request. But when he does act it is without perceptible delay, and often indeed very rapidly, while in retarded cases every separate movement is effected slowly and hesitatingly, as they frequently demonstrate in simply raising the hands or in counting. Here also many requested movements are wholly omitted, but are suppressed by anxiety or strong retardation, since one often sees the disposition to perform the movement (slight movements of the lips, twitching of fingers, etc.), especially when the retardation is overcome by strong persuasion.

Inversely one can observe in catatonics that an apparent impulse is interrupted at the very beginning, annulled, and perhaps changed to its very opposite. Lack of affect in catatonia is strongly emphasized by Kraepelin.

The differentiation of melancholia from paresis is sometimes very difficult. These cases especially which occur between the ages of forty-five and fifty-five can remain in doubt for a long time, as the psychic disease picture is very similar. Greater clearness and consciousness, lively uniform affect, and subacute development speak more for melancholia, while in paresis we see psychic weakness (forgetfulness, defective time orientation, indifference, loss of judgment, silly and contradictory delusions, impairment of morals, and feeble affect). It must be remembered that paresis is a deterioration process from the start, the development is slow, and some at least of the characteristic physical symptoms are present, as slurring speech, ataxia, incoordination, tremors, pupillary inequalities, etc.

In senile dementia the depression is due to delusions of persecution—(robbery, frauds, etc.); is usually transi-

tory; and can be often transformed into the exact opposite by trivial causes. Here the age at onset and the characteristic senile alterations will usually be conclusive.

The prodromal period of melancholia is difficult to distinguish from neurasthenia, especially when the latter follows an acute disease or appears in a neuropathic individual. The appearance of apathy without sufficient cause, of delusions of reference or persecution, with primary fear and self-accusations, point to melancholia.

The depression found in hysteria needs merely a mention, as the symptoms of this disorder are more familiar to the general practitioner than to the hospital physician.

CONCLUSIONS.

The salient features in connection with depression in various psychoses are:—

DEMENTIA PRECOX.

Depression transient.

Lack of affect is pronounced and very characteristic, especially in Catatonia.

Hallucinations and delusions prominent.

MELANCHOLIA.

Depression marked and permanent.

Prominence of fear.

Affect marked and in accord with delusions.

Hallucinations not essential.

Self-accusations.

Suicidal attempts.

MANIC-DEPRESSIVE INSANITY.

Depression severe but not permanent.

Affect less than in melancholia.

Self-accusations rare.

Retardation a prominent and characteristic symptom.

DEMENTIA PARALYTICA.

Depression less intense.

Little or no affect.

Retardation and fear absent.

Deterioration rapid.

RETARDATION OF THOUGHT.

Disturbances of the train of thought are uniformly frequent in the different forms of insanity. Unfortunately, however, they have hitherto been insufficiently investigated.

The simplest form is the flagging of the course of ideas through diminution of intellectual activity. In the first place there arises a more or less powerful retardation of thought, with which further on changes are associated, especially monotony and distractibility. Light grades are found in fatigue—severe forms in poisoning by narcotics. Further, intellectual paralysis forms the general characteristic feature in the most varied forms of deterioration—as dementia paralytica, dementia precox, senility, etc.

In retardation the elaboration of external impressions is effected laboriously and slowly; the train of thought is powerfully delayed and prolonged; and the store of ideas is exceedingly imperfect. Sometimes this mental constraint can proceed to almost complete cessation of thought.

Patients clearly perceive the resistance which they have to combat. They do not lack mental activity; they are not obtuse and indifferent like weak-minded or deteriorated patients, but are unable, even with the greatest exertion, to overcome the constraint and narrowness of their thought. We encounter this disturbance most distinctly in the depressive and mixed forms of manic-depressive insanity; possibly also certain disturbances of thought in epileptic stupor are to be included here.